2009 Benefits At A Glance

In-Network Benefits - per plan year (unless otherwise stated)	**COVA Care/ COVA Connect** You Pay	**COVA HDHP** You Pay	**Kaiser Permanente** You Pay
Deductible			
• One person	$225	$1,200	None
• Two or more persons	$450	$2,400	None
Out-of-pocket expense limit			
• One person	$1,500	$5,000	$3,500
• Two or more persons	$3,000	$10,000	$9,400
Doctor's visits			
• Primary Care Physician	$25	20% after deductible	$10
• Specialist	$40	20% after deductible	$20
Hospital services			
• Inpatient	$300 per stay	20% after deductible	$100 per admission
• Outpatient	$125 per visit	20% after deductible	$50 per visit
Emergency room visits	$125 per visit (waived if admitted)	20% after deductible	$75 per visit (waived if admitted)
Outpatient diagnostic, lab tests, shots and x-rays	20% after deductible	20% after deductible	$0 lab, pathology, radiology, diagnostic testing
Infusion Services	20% after deductible	20% after deductible	$10
Outpatient therapy visits			
• Occupational, physical and speech therapy	$35	20% after deductible	$20
• Chiropractic	$35	20% after deductible	$20
Behavioral Health visits			
• Non-medical professional*	$25	20% after deductible	$20
• Medical professional	$40	20% after deductible	$20
Employee Assistance Program (EAP) *Up to 4 visits per incident*	$0	$0	$0
Prescription drugs – mandatory generic			
• Retail Pharmacy	*Up to 34-day supply:* $15/$25/$40/$50	*Up to 34-day supply:* 20% after deductible	*Up to 60-day supply* • Medical Center Pharmacy: $10/$20/$35 • Community participating pharmacy: $20/$40/$55
• Home Delivery Pharmacy (Mail Service)	*Up to 90-day supply* $30/$50/$80/$100	*Up to 90-day supply* 20% after deductible	*Up to 90-day supply* $8 /$18/$33

*Includes licensed professionals with a master's or PhD degree.

In-Network Benefits	COVA Care/ COVA Connect You Pay	COVA HDHP You Pay	Kaiser Permanente You Pay
Wellness & Preventive Services	$0	$0	$0
• Through age 6	• Office visits at specified intervals, immunizations, lab and x-rays		
• Age 7 and older	• Annual check-up visit (primary care or specialist), immunizations, lab and x-rays		
• Adult	• Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening.		
Basic Dental			
Maximum Benefit - per member (except Orthodontic)	$2,000	$2,000	$1,000
Deductible	$50/$100/$150	$50/$100/$150	$25 per person
Diagnostic and preventive	$0, no deductible	$0, no deductible	See fee schedule
Primary (basic) care	20% after deductible	20% after deductible	See fee schedule

COVA Care and COVA Connect Optional Buy-Ups for Additional Premium

Routine Blue Vision & Hearing Buy-Up

Vision

COVA Care routine vision benefits are now available from Blue View Vision℠. COVA Connect routine vision benefits are available from EyeMed Vision Care. Benefits are available once every 24 months and the count begins on the date you receive your eye examination or purchase eyeglass frames or lenses. You may see a network optician, optometrist or go to a retail setting for your eye exam and for purchasing lenses and frames. Non-network benefits will apply if you visit a provider who is not in the network. To find a Blue View provider, visit www.anthem.com/cova. COVA Connect: To fine an EyeMed provider, visit www.eyemedvisioncare.com.

	Covered Services	In-Network	Non-Network
NEW Routine Vision Blue View Vision Network (once every 24 months)	■ Routine eye exam	You pay $40	Plan pays up to $50
	■ Eyeglass lenses	You pay $20	Plan pays up to: $50 single lenses; $75 bifocal; $100 trifocal
	■ Eyeglass frames	Plan pays up to $100* retail allowance	Plan pays up to $80
	■ Contact lenses *(in lieu of eyeglass lenses)*		
	• Elective [1]	Plan pays up to $100* allowance	Plan pays up to $80
	• Non-Elective [1]	Plan pays up to $250 allowance	Plan pays up to $210
	■ Lens options		
	• UV coating, tints, standard scratch-resistant	You pay $15	Not available
	• Standard polycarbonate	You pay $40	Not available
	• Standard progressive	You pay $65	Not available
	• Standard anti-reflective	You pay $45	Not available
	• Other add-ons	You pay 20% off retail	Not available

*You may select a frame or contact lenses greater than the covered allowance. You receive a 20% discount for any frames or a 15% discount for contact lenses for additional cost over the allowance.

[1] Elective contact lenses are typically elected in lieu of eyeglass lenses. Non-Elective contact lenses are medically necessary contacts when glasses are not an option for vision correction.

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Hearing

	Covered Services	You Pay
Hearing *(once every 48 months)*	■ Routine hearing exam	$40
	■ Hearing aids and other hearing aid related services	$0
	■ Benefit Maximum	$1,200

Expanded Dental Buy-Up

Plan Year Deductible	$50/$100/$150
Plan Year Maximum Per Member	$2,000
Complex Restorative (inlays, onlays, crowns, dentures, bridgework)	You pay 50% after deductible
Orthodontic Services	You pay 50%, no deductible
Orthodontic Lifetime Maximum Per Member	$2,000

Out-of-Network Option Buy-Up

You are responsible for any deductible, copayment or coinsurance that applies. Plan payment is reduced by 25 percent. The provider may balance bill for any amount above the allowable charge.